FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005439

Facility Name: METHODIST HOME

Address: 1415 WEST FOSTER AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 769-5500 **Fax #** (773) 769-6287

IDPA ID Number: 36-2210011001

Date of Initial License for Current Owners: UNKNOWN

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jim Zoros, Chief Financial Officer **Telephone Number:** (773) 769-5500

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 03/17/06 (Date)

(Type or Print Name) William A. Lowe

(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 06/21/05

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	23	Skilled (SNF)	111	25,467	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	10	18,698	3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,380	5
6		ICF/DD 16 or Less			6
7	133	TOTALS	133	48,545	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,527	6,391	2,879	20,797	8
9	SNF/PED					9
10	ICF	9,288	4,952		14,240	10
11	ICF/DD					11
12	SC	157	948	3	1,108	12
13	DD 16 OR LESS					13
14	TOTALS	20,972	12,291	2,882	36,145	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.46%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Senior Fitness

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1898

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 111 and days of care provided 2,879

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	302,177	28,275	103,821	434,273		434,273		434,273			1
2	Food Purchase		223,870		223,870		223,870	(6,668)	217,202			2
3	Housekeeping	165,000	39,255		204,255		204,255	(12,000)	192,255			3
4	Laundry	38,423	12,677		51,100		51,100		51,100			4
5	Heat and Other Utilities			173,288	173,288		173,288		173,288			5
6	Maintenance	145,992	27,569	56,074	229,635		229,635	(6,360)	223,275			6
7	Other (specify):*											7
8	**TOTAL General Services**	651,592	331,646	333,183	1,316,421		1,316,421	(25,028)	1,291,393			8
	B. Health Care and Programs											
9	Medical Director			37,799	37,799		37,799		37,799			9
10	Nursing and Medical Records	1,855,393	120,852	15,237	1,991,482		1,991,482		1,991,482			10
10a	Therapy	65,979	5,095	8,899	79,973		79,973		79,973			10a
11	Activities	86,395	4,324	8,007	98,726		98,726		98,726			11
12	Social Services	55,256	2,118	18,601	75,975		75,975		75,975			12
13	CNA Training											13
14	Program Transportation			2,168	2,168		2,168	(2,168)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,063,023	132,389	90,711	2,286,123		2,286,123	(2,168)	2,283,955			16
	C. General Administration											
17	Administrative							82,815	82,815			17
18	Directors Fees											18
19	Professional Services			177,139	177,139		177,139		177,139			19
20	Dues, Fees, Subscriptions & Promotions			61,234	61,234		61,234	(36,893)	24,341			20
21	Clerical & General Office Expenses	406,454	31,770	72,990	511,214		511,214	(48,501)	462,713			21
22	Employee Benefits & Payroll Taxes			593,105	593,105		593,105	4,039	597,144			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,775	12,775		12,775	(2,566)	10,209			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			191,287	191,287		191,287		191,287			26
27	Other (specify):*											27
28	**TOTAL General Administration**	406,454	31,770	1,108,530	1,546,754		1,546,754	(1,106)	1,545,648			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,121,069	495,805	1,532,424	5,149,298		5,149,298	(28,302)	5,120,996			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number METHODIST HOME #0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			228,276	228,276		228,276		228,276			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,735	55,735		55,735	(55,735)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,712	9,712		9,712		9,712			35
36	Other (specify):*											36
37	**TOTAL Ownership**			293,723	293,723		293,723	(55,735)	237,988			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		328,168	230,231	558,399		558,399		558,399			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,248	66,248		66,248		66,248			42
43	Other (specify):* Marketing/HRA D	47,750		6,364	54,114		54,114	(54,114)				43
44	**TOTAL Special Cost Centers**	47,750	328,168	302,843	678,761		678,761	(54,114)	624,647			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,168,819	823,973	2,128,990	6,121,782		6,121,782	(138,151)	5,983,631			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,668)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,351)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(55,735)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,104)	21		24
25	Fund Raising, Advertising and Promotional	(9,789)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(27,104)	20		28
29	Other-Attach Schedule	(104,254)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (225,005)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (225,005)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

METHODIST HOME

ID# 0005439

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Winwood Revenue - Maintenance	$ (6,360)	6	1
2	Winwood Revenue - Housekeeping	(12,000)	3	2
3	Winwood Revenue - Management	(18,972)	21	3
4	Miscellaneous Income	(5,924)	21	4
5	Marketing	(47,750)	43	5
6	Marketing	(2,150)	21	6
7	Non Allowable Seminar Costs	(2,566)	24	7
8	Health Resources Alliance Dues	(6,364)	43	8
9	Resident Transportation Fees (to the extent of exp)	(2,168)	14	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(104,254)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number METHODIST HOME # 0005439 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,668)	0	0	0	0	0	0	0	0	0	0	(6,668)	2
3	Housekeeping	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(6,360)	0	0	0	0	0	0	0	0	0	0	(6,360)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(25,028)	0	0	0	0	0	0	0	0	0	0	(25,028)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,168)	0	0	0	0	0	0	0	0	0	0	(2,168)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,168)	0	0	0	0	0	0	0	0	0	0	(2,168)	16
	C. General Administration													
17	Administrative	0	82,815	0	0	0	0	0	0	0	0	0	82,815	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(36,893)	0	0	0	0	0	0	0	0	0	0	(36,893)	20
21	Clerical & General Office Expenses	(48,501)	0	0	0	0	0	0	0	0	0	0	(48,501)	21
22	Employee Benefits & Payroll Taxes	0	4,039	0	0	0	0	0	0	0	0	0	4,039	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,566)	0	0	0	0	0	0	0	0	0	0	(2,566)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(87,960)	86,854	0	0	0	0	0	0	0	0	0	(1,106)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(115,156)	86,854	0	0	0	0	0	0	0	0	0	(28,302)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number METHODIST HOME **#** 0005439 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(55,735)	0	0	0	0	0	0	0	0	0	0	(55,735)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(55,735)	0	0	0	0	0	0	0	0	0	0	(55,735)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(54,114)	0	0	0	0	0	0	0	0	0	0	(54,114)	43
44	**TOTAL Special Cost Centers**	(54,114)	0	0	0	0	0	0	0	0	0	0	(54,114)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(225,005)	86,854	0	0	0	0	0	0	0	0	0	(138,151)	45

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				NAPER VALLEY CO	CHICAGO	INACTIVE
UNITED METHODIST HOMES & SERVIC	100 %			UMH&S FOUNDATI	CHICAGO	FOUNDATION
				WINWOOD APARTM	CHICAGO	ELDERLY HOUSIN

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	17	Administrator - Allocated Salary Expense		UNITED METHODIST HOMES & SERVICES FOUNDATION	100.00%	82,815	82,815	2
3	V								3
4	V	22	Administrator - Allocated FICA Expense		UNITED METHODIST HOMES & SERVICES FOUNDATION	100.00%	4,039	4,039	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 86,854	$ * 86,854	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: UMH&S FOUNDATION
Street Address: 1415 W. FOSTER AVE.
City / State / Zip Code: CHICAGO, IL 60640
Phone Number: (773) 769-5500
Fax Number: (773) 769-6287

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrator Salary Expense	# of Hours	2	1	$ 165,630	$ 165,630	1	$ 82,815	1
2	22	Administrator FICA Expense	# of Hours	2	1	8,078	0	1	4,039	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 173,708	$ 165,630		$ 86,854	25

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bonds		X	Refinance & Renovations		07/20/98	$ 1,225,761	$ 1,176,761	07/20/23	Various	$ 49,900	1
2												2
3												3
4												4
5							Interest Income Offset (to the extent of expense)				(55,735)	5
	Working Capital											
6	Harris Bank		X	Working Capital		Various	300,000				5,835	6
7												7
8												8
9	TOTAL Facility Related						$ 1,525,761	$ 1,176,761			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,525,761	$ 1,176,761			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number METHODIST HOME **#** 0005439 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000		8
	2001		9
	2002		10
	2003		11
	2004		12

N/A - Facility is not subject to real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME METHODIST HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005439

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - Facility is not subject to real estate taxes		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,281 B. General Construction Type: Exterior BRICK Frame CONCRETE BLOCK Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Related business entities are identified on page 6, Schedule VII - Related Parties. Specific facilities located adjacent to The Methodist Home are:

Winwood Apartments, Inc. - 1406 W. Winona - a 31 unit HUD subsidized apartment building for very low income adults.

Glenwood Apartments - 5027 N. Glenwood - a 13 unit apartment complex for very low income adults.

Foster Apartments - 1433 W. Foster - 2 flat - intergenerational housing.

Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services and UMH&S Foundation as well as rental space for White Crane Wellness Center.

The costs for these entities are segregated and not included as part of the financial information presented on this report for The Methodist Home.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HEALTH CARE	39,375	1898-1950	$ 25,000	1
2					2
3	TOTALS	39,375		$ 25,000	3

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42			1922	$ 214,000	$		$	$	$ 214,000	4
5	48			1951	297,000					297,000	5
6				1972	941,207					941,207	6
7	8			1973	541,942					541,942	7
8	35			1974	479,275					479,275	8
	Improvement Type**										
9	ELEVATOR; HEATING AND A/C SYSTEM			1975	898,240		25			898,240	9
10	BEAUTY SHOP AND SWIFT OFFICE			1976	1,203		20			1,203	10
11	NURSING OFFICE AND CONFERENCE ROOM PARTITION			1980	1,300		20			1,306	11
12	DINING AND BOILER ROOM			1983	215		20			215	12
13	DOOR ALARMS			1984	1,188		20			1,188	13
14	SIDEWALK; PAVEMENT			1985	7,958	199	20	199		7,958	14
15	FENCING			1986	31,965	1,598	20	1,598		31,165	15
16	SIDEWALK			1987	3,680	184	20	184		3,404	16
17	ROOF & LIGHTING			1988	41,556		10			41,556	17
18	PARKING LOT			1989	123,634		10			123,634	18
19	GROUND FLOOR BATHROOMS AND BEAUTY SHOP			1990	81,482		10			81,555	19
20	1ST FLOOR COMMON AREAS			1991	155,195		10			154,296	20
21	1ST FLOOR ROOM RENOVATIONS 7 2ND FLOOR NURSING STATI			1992	224,277		10			219,394	21
22	LIVING ROOM & 2ND FLOOR HALLWAYS			1993	211,680		10			205,150	22
23	3RD FLOOR RENOVATIONS & 4TH FLOOR NURSES STATION			1994	239,782	312	10	312		233,315	23
24	4TH FLOOR RENOVATIONS & ADMINISTRATIVE OFFICES			1995	143,955	7,203	10	7,203		143,752	24
25	REPLACE CHILLER (AIR CONDITIONING SYSTEM)			1996	264,240	15,658	10	15,658		148,748	25
26	3RD FLOOR RENOVATIONS & SEWER LINE			1997	50,445	6,943	10	6,943		43,791	26
27	NURSING STATION - 2ND FL, DOOR ALARM SYSTEM - 4TH FL, CE			1998	70,774	7,056	10	7,056		52,920	27
28	AUTOMATIC DOOR - LOBBY, 4TH FLOOR - TILE & RENOVATION,			1999	33,593	2,998	10	2,998		19,487	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Carpeting 1988 - 1992		52,134		5			52,134	38
39	Carpeting	1993	14,437		5			14,437	39
40	Carpeting	1994	21,507		5			21,507	40
41	Carpeting	1995	18,800		5			18,800	41
42	Carpeting	1996	17,235		5			17,235	42
43	Carpeting	1997	5,198		5			5,198	43
44	Carpeting	1998	39,439		5			39,439	44
45	Carpeting	1999	531		5			531	45
46									46
47	Main Stairway Upgrade, Plumbing, Remodeling of Resident Rooms - Floor	2000	76,700	7,670	10	7,670		42,185	47
48	Main Elevator Upgrade	2000	38,713	1,936	20	1,936		10,648	48
49	Air Conditioner - Circulation Pump Replacement	2000	787	31	25	31		171	49
50	Carpeting - 4th Floor, Main Stairway, Rooms - 57, 70, 74	2000	12,458	1,244	5	1,244		12,458	50
51	Parking Lot Improvements - Concrete Replacement, Trees, Fence	2000	7,596	760	10	760		4,180	51
52									52
53	1st Floor Nursing Station Remodeling, Flooring - 2nd Fl Dining Roo	2001	81,554	8,155	10	8,155		36,698	53
54	Heat & A/C - Multistack A/C Unit, Chiller Condensor Bypass Filter	2001	13,647	546	25	546		2,457	54
55	Carpeting - Rms. 55, 75, 79, LL Corridor, 1st Fl Conf. Room	2001	6,120	1,224	5	1,224		5,508	55
56									56
57	Fire Alarm System, 2nd Fl Nursing Station & Dining Room Remod	2002	235,781	23,578	10	23,578		82,523	57
58	Main Elevator Upgrade	2002	4,965	248	20	248		868	58
59	Carpeting - Resident Services Office, Rm 48, Front Entrance	2002	2,656	531	5	531		1,859	59
60	Parking Lot Improvements - Seal Coating	2002	2,375	238	10	238		833	60
61									61
62	Magnetic Door System, Renovation-Senior Fit Area, Resident Room	2003	199,523	19,952	10	19,952		49,880	62
63	Carpeting - Resident Rooms 64, 80, Res. Svc Office, Adm. Office	2003	1,349	270	5	270		675	63
64	Lighting Retro Fit, Sewage Ejector Pumps, Emergency Generator I	2003	29,290	1,465	20	1,465		3,662	64
65									65
66	Resident Room Remodeling, Magnetic Door System, 4th Fl Nursing	2004	50,774	5,077	10	5,077		7,617	66
67	Ejector Pump - Rehab Office, Fire Dampers, Drain for Wash Mach	2004	4,854	243	20	243		364	67
68	Stairway Ramp Renovation - Parking Lot	2004	3,224	322	10	322		483	68
69	Carpeting - Main Lobby, 1st Floor, 3rd Floor	2004	25,194	5,039	5	5,039		7,558	69
70	TOTAL (lines 4 thru 69)		$ 6,026,627	$ 120,680		$ 120,680	$	$ 5,325,609	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,026,627	$ 120,680		$ 120,680	$	$ 5,325,609	1
2									2
3	Fire Alarm System & Smoke Detectors, Resident Room Remodeling	2005	233,482	11,674	10	11,674		11,674	3
4	Kitchen Sewage Pump, Boiler Feed and Ejector Pumps	2005	6,887	172	20	172		172	4
5	Trees/Grounds/Landscaping Work	2005	4,325	216	10	216		216	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,271,321	$ 132,742		$ 132,742	$	$ 5,337,671	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,135,318	$ 86,051	$ 86,051	$		$ 727,814	71
72	Current Year Purchases	31,333	1,567	1,567			1,567	72
73	Fully Depreciated Assets	632,412					632,412	73
74								74
75	TOTALS	$ 1,799,063	$ 87,618	$ 87,618	$		$ 1,361,793	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORTATI	FORD BUS, 2002	2001	$ 54,399	$ 7,916	$ 7,916	$		$ 53,284	76
77										77
78										78
79										79
80	TOTALS			$ 54,399	$ 7,916	$ 7,916	$		$ 53,284	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,149,783	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 228,276	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 228,276	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,752,748	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 9,712 Description: Copiers - Leased
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39,C3	hrs	$	1,892	$ 89,988	$	1,892	$ 89,988	1
2	Licensed Speech and Language Development Therapist	L39,C3	hrs		513	14,989		513	14,989	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39,C3	hrs		1,859	109,035		1,859	109,035	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescrpts				300,463		300,463	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Suppl, Lab, X-Ra	L39,C2,C3				16,219	27,705		43,924	13
14	TOTAL			$	4,264	$ 230,231	$ 328,168	4,264	$ 558,399	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number METHODIST HOME **#** 0005439 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 62,387	$	1
2	Cash-Patient Deposits	46,639		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 140,580)	707,384		3
4	Supply Inventory (priced at)	22,858		4
5	Short-Term Investments			5
6	Prepaid Insurance	10,732		6
7	Other Prepaid Expenses	2,288		7
8	Accounts Receivable (owners or related parties)	1,949,786		8
9	Other(specify): A/R - Misc Receivables	488		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,802,562	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	303,264		12
13	Land	25,000		13
14	Buildings, at Historical Cost	6,271,321		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,853,462		16
17	Accumulated Depreciation (book methods)	(6,752,748)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Financing Costs	20,874		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,721,173	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,523,735	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 227,617	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	101,639		28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable	324,929		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,135		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unexpended Restricted Gifts	39,316		36
37	Due to Third-Party Payor	40,167		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 937,803	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	976,761		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 976,761	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,914,564	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,609,171	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,523,735	$	48

***(See instructions.)**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,785,752	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,785,752	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(176,581)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (176,581)	17	
	B. Transfers (Itemize):			
18	**Equity Transfers from UMH&S Foundation**	1,000,000	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,000,000	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,609,171	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,060,429	1
2	Discounts and Allowances for all Levels	(1,208,919)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,851,510	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	437,499	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 437,499	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,668	14
15	Telephone, Television and Radio	5,351	15
16	Rental of Facility Space		16
17	Sale of Drugs	349,488	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,771	19
20	Radiology and X-Ray	3,223	20
21	Other Medical Services	118,435	21
22	Laundry	14,470	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 513,406	23
	D. Non-Operating Revenue		
24	Contributions	10,200	24
25	Interest and Other Investment Income***	80,018	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 90,218	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	WW Apts Revenue (Adjusted Out - Page 5)	37,332	28
28a	Other - See attached Schedule	15,236	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 52,568	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,945,201	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,316,421	31
32	Health Care	2,286,123	32
33	General Administration	1,546,754	33
	B. Capital Expense		
34	Ownership	293,723	34
	C. Ancillary Expense		
35	Special Cost Centers	612,513	35
36	Provider Participation Fee	66,248	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,121,782	40
41	**Income before Income Taxes (line 30 minus line 40)****	(176,581)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (176,581)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,820	2,065	$ 77,855	$ 37.70	1
2	Assistant Director of Nursing	464	520	15,700	30.19	2
3	Registered Nurses	20,838	23,472	625,220	26.64	3
4	Licensed Practical Nurses	12,044	13,477	310,478	23.04	4
5	CNAs & Orderlies	75,322	82,077	794,861	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,597	5,050	65,979	13.07	8
9	Activity Director	1,583	1,754	32,296	18.41	9
10	Activity Assistants	4,221	4,618	54,099	11.71	10
11	Social Service Workers	3,306	3,606	55,256	15.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,789	4,312	53,612	12.43	14
15	Cook Helpers/Assistants	17,731	19,752	183,654	9.30	15
16	Dishwashers	7,403	8,035	64,911	8.08	16
17	Maintenance Workers	6,432	7,065	145,992	20.66	17
18	Housekeepers	17,555	19,013	165,000	8.68	18
19	Laundry	3,749	4,245	38,423	9.05	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	18,706	20,104	406,454	20.22	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,788	1,926	30,487	15.83	31
32	Other Health Care(specify)					32
33	Other(specify) See Suppl Sched.	1,428	1,592	48,542	30.49	33
34	TOTAL (lines 1 - 33)	202,776	222,683	$ 3,168,819 *	$ 14.23	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	520	37,799	L9,C3	36
37	Medical Records Consultant	104	4,576	L10,C3	37
38	Nurse Consultant	292	10,661	L10,C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,400	L11,C3	44
45	Social Service Consultant	49	2,559	L12.C3	45
46	Other(specify) Rehab Consulting	198	8,899	L10a,C3	46
47	Dietary Management Fees	Monthly	99,310	L1,C3	47
48	Senior Fit Consultant	208	7,002	L39,C3	48
49	TOTAL (lines 35 - 48)	1,419	$ 173,206		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Larry Loecker -	Administrator		$
(Allocation on p6 & p8)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Audit	$ 11,914
FR&R Consulting	Accounting/Consulting	90,158
Provinet Solutions	Data Processing	32,125
React Computer Services	Data Processing	2,856
M. J. Kelly	Data Processing	10,665
E-Health Data Solutions	Data Processing	3,420
Kronos	Payroll	1,410
Paychex	Payroll	15,582
Accounting Solutions	Payroll	199
Universal Tax Systems	Accounting/Data Processing	275
Other - See attached schedule		8,535
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 177,139

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,359
Unemployment Compensation Insurance	83,341
FICA Taxes	246,365
Employee Health Insurance	213,289
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Recognition	15,790
TOTAL (agree to Schedule V, line 22, col.8)	$ 597,144

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,107
Health Care Worker Background Check	3,000
(Indicate # of checks performed 383)	
Books & Subscriptions	8,007
Membership Fees	9,992
Resident Relations	1,235
Advertising	36,893
Less: Public Relations Expense	( )
Non-allowable advertising	(9,789)
Yellow page advertising	(27,104)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,341

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	712
Seminar Expense	9,497
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,209

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Life Services Network of IL - $4,741**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **63,580** Line **L10,C2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **66,248**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **6,668**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of L14,
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **FROST, RUTTENBERG & ROTHBLATT, P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.